



2010

# IMPROVING HEALTH EQUITY THROUGH LANGUAGE ACCESS:

A Model for Integrated Language Services  
throughout the Toronto Central LHIN

**SickKids®**  
THE HOSPITAL FOR  
SICK CHILDREN

 **Ontario**  
Toronto Central Local Health  
Integration Network

## About the Toronto Central LHIN

In 2006, through the Local Health System Integration Act, the planning of health services was shifted along with funding and management through Local Health Integration Networks (LHIN). There are 14 not-for-profit LHINs across Ontario. The LHINs enable the health care system to be patient-focused, results-driven, integrated and sustainable from hospital to community. Each LHIN works at the community level to facilitate effective and efficient integration of health care services across sectors.

The Toronto Central LHIN funds 177 unique health service providers that include community health centres, community support services, a community care

access centre, hospitals, long-term care homes and mental health and addiction services. The TC LHIN is home to a large immigrant population which makes up 41% of the population in the area ([www.torontocentrallhin.on.ca](http://www.torontocentrallhin.on.ca)). This is almost twice the percentage found across the rest of Ontario. A large number of immigrants have limited or no knowledge of English and this influences their access to health care services. The TC LHIN in collaboration with its community of health care providers identified language services as a priority in order to address issues of health equity for all of its citizens. This partnership is an effort to ensure the best use of available resources in order to meet the needs of the community.

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## About SickKids

The Hospital for Sick Children (SickKids) is a world renowned academic health science centre devoted to the tertiary and quaternary care of children ([www.sickkids.ca](http://www.sickkids.ca)). SickKids is situated in the heart of downtown Toronto and serves a diverse patient population requiring interpretation in as many as 45 languages. SickKids has been a leader in delivering high quality interpretation services and is excited to lead the development of an integrated language service model in collaboration with the TC LHIN.

This project is well-aligned with SickKids' strong commitment to health equity, and excellence in quality care and customer service. SickKids as well is the recipient of a generous grant from Citizenship and Immigration Canada (CIC) to develop cultural competence programs and materials for providers, patients and their families, as well as translation of key patient care documents into several different languages. This work will be leveraged to further the success of the TC LHIN Interpretation Project.

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The Toronto Central Local Health Integration Network (TC LHIN) has focused on issues of health equity by identifying health disparities or inequities in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage. Toronto is recognized as one of the most ethnically diverse cities in the world, making translation and interpretation services a top area of interest for the TC LHIN in terms of opportunity to explore innovations to address the healthcare needs of the population.

There have been numerous recommendations for interpretation services over the last two decades, yet little has changed in Ontario. Gaps include lack of legislation and policy, inconsistent use of interpreter services, and inconsistency in application of standards for training and testing of interpreters. Toronto's unique challenges for delivery of language services include the variety of languages spoken, different sectors having different needs, and increasing complexity of care both in hospital and in the community, requiring optimal communication.

Many other countries have instituted legislation to ensure citizens who have limited English proficiency (LEP) receive the same quality of care as English speaking patients. The legislation serves as the foundation for language service systems in parts of the United States, Australia and the United Kingdom. Leading practice organizations demonstrate the benefits of a coordinated, centralized delivery

service with secured funding structures. Advantages include greater efficiency and consistent delivery of quality services which has been shown to reduce risk of error, reduce unnecessary tests, procedures, emergency visits and admissions and increased satisfaction of patients and staff.

Key components of the proposed TC LHIN Centralized Integrated Interpretation Service include:

- Maximizing human resources through sharing among organizations and sectors,
- Utilizing routing technology to create a more efficient network of remote services, and
- Ensuring consistent policies and standards for interpreter services across sectors

Providing interpretation at critical points in the delivery of health care is a matter of health equity and patient safety. This document is not meant to be a call for discussion of the issues surrounding language and communication; the needs are clear and well documented. This is a call to action. Included is an Implementation Roadmap to guide the realization of an efficient and effective interpretation service with flexibility to expand and adapt according to changing demographics, standardized evaluation measures and quality indicators. The business case predicts savings to the TC LHIN over time to sustain the service with the possibility of offering the service to other sectors (e.g. business, legal).





In July 2008, the TC LHIN published a health equity discussion paper in an attempt to identify and address health disparities or inequities in health outcomes that are avoidable, unfair and systematically related to social inequality. Given that Toronto is one of the most ethnically diverse cities in the world with approximately 160 languages and dialects spoken and many residents who have no or limited proficiency with the English language, translation and interpretation services (including sign language) were identified as one of the top areas of interest in terms of opportunities to explore innovations in technology and shared services to address the healthcare needs of the central Toronto population.

The literature indicates language barriers have a significant impact on quality of health care. In order for providers

to be effective there is a need for a mutual understanding of the patient's health status. As well, practitioners need to be able to explain the individual risks and benefits of interventions to enable patients and their family members to meaningfully participate in decision-making and to obtain informed consent. Patient safety literature identifies language barriers as a limitation to informed consent and a contributor to preventable morbidity and mortality. An inability to communicate and share information can lead to delays in necessary services and decreased satisfaction for patients and families. The cost of not using language services has been linked to adverse events, excessive or unnecessary tests, prolonged hospital stays, more emergency room use, limitations to follow-up care, and increases in 'no-show' appointments resulting in a significant increase in health care provider time.



Canada's health care system has evolved into a universal system in order to support the needs of Canadians on a fair and equitable basis. The Canada Health Act (1984) identifies principles to guide provinces in designing their health care delivery systems in ways that ensure Canadians have "reasonable access to health services without financial or other barriers." The principles of Accessibility, Universality and Comprehensiveness are foundational to the current and future strength of the health care system and are becoming even more relevant as our population becomes increasingly ethnically diverse due to evolving immigration patterns. The increase in our immigrant population has led to the growing need for language services to systematically reduce actual and potential disparities in health.

Although Accessibility, Universality and Comprehensiveness are not explicitly described and often are open to a degree of interpretation, we can assume that the spirit of the Act leads one to believe the following:

- Accessibility refers to the provision of insured health services without barrier to reasonable access by all insured persons.
- Universality requires that 100% of citizens be entitled to insured services on the same terms and conditions, and
- Comprehensiveness implies that a health insurance plan cover all insured health services that are medically necessary for the purpose of maintaining health, preventing disease, or managing an acute or chronic medical problem and these services are provided by hospitals, medical practitioners, dentists and as well as other identified services provided by other providers.

LEP Patients and clients are challenged to interact effectively with health care providers. Because of language differences, LEP persons can be excluded from health care services, experience delays or denials of health care services or receive health care services based on inaccurate or incomplete information. One could argue that not offering interpreter services may impede access, limiting universality and challenge comprehensiveness by not ensuring communication that could be construed as medically necessary.

Another relevant law that can be directly applied to an individual's rights to equal access to healthcare is the Canadian Charter of Rights and Freedoms. The Charter states, "Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical ability." In 1997, an interpretation of the Charter was used in the Supreme Court to defend the human rights of persons with hearing impairment who required communication through American Sign Language (ASL). The court found that not providing a sign language interpreter impaired their ability to communicate with health care providers, and increased the risk of misdiagnosis and ineffective treatment. Although, the ruling does not explicitly address language barriers other than ASL, one could conclude that failing to supplying a language interpreter may cause LEP patients to receive inefficient or suboptimal care processes and outcomes.

A number of predominantly English speaking countries have instituted legislation to ensure citizens who have limited English proficiency have access to the same quality of care as English-speaking patients. The legislation serves as the foundation of language service systems in parts of the United States, Australia and the United Kingdom. New legislation in Ontario addresses access to services for persons with disabilities. Through the Accessibility for Ontarians with Disabilities Act (2005), standards have been requested of public organizations to facilitate equitable access to service for persons with disabilities. The standards are meant to assist organizational change for optimizing the health care experience for patients and clients who need accommodation. Accommodating the communication needs of persons with LEP requires similar attention given rapidly changing demographics specifically within urban settings.

The implementation of a model for centralized integrated interpreter services within the TC LHIN could potentially be the impetus leading to legislation that facilitates optimal delivery of language services in health care settings broadly and ensuring health equity for all Ontarians.

## Project Description

In October 2009, this TC LHIN driven initiative commenced with SickKids as the lead organization to develop an innovative model meeting mutually identified needs for interpretation in health care including standardizing the role of interpreters, developing strategies to address language access issues in a variety of health care situations, identifying optimal service modalities and recommending the integrated use of a shared technology solution and shared language human resources.

The TC LHIN/SickKids partnership sought to identify interventions to improve interpretation and translation services within and across health care sectors. Consideration of challenges in developing an effective model due to the unique complexities within the TC LHIN was a necessary part of the development process, particularly because increased immigration patterns highlight the

need for services for over 100 languages. As well, an aging population leads to an increase in complex illness with multiple co-morbidities. These patients require clear and understandable communication to allow for self-care. Organizations have actively developed systems and processes to meet their own patient care needs in isolation of other organizations and stakeholders. Language service strategies need to be consistent so health care delivery can be seamless across the continuum of care.

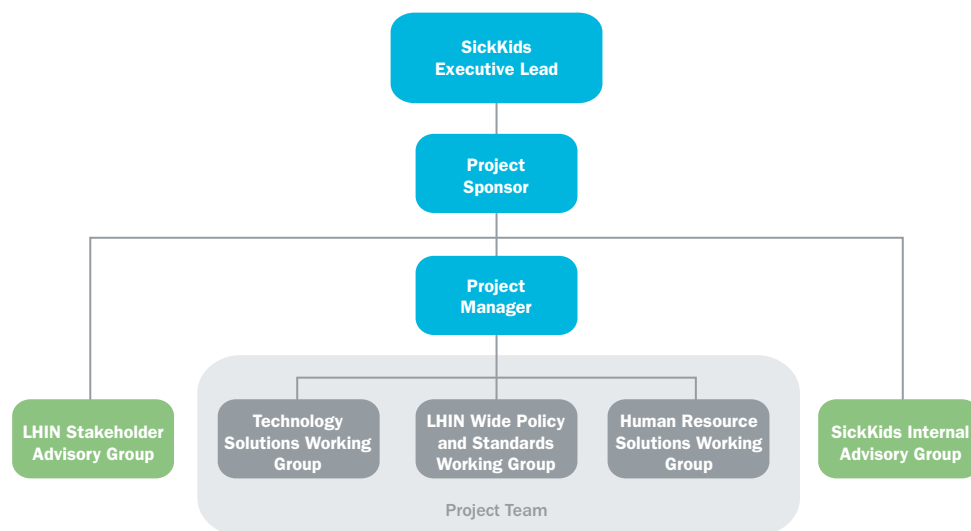
The project partners envision this innovative approach to language services as an expandable, coordinated resource that is both an efficient framework for delivering professional language services and a cost-effective strategy to improve access to care and health equity for all patients and families who require spoken or sign language interpretation.

## Project Team Structure

To best support the project and to ensure the perspectives of various stakeholders were appropriately represented, a committee infrastructure was established that was made up of members from both SickKids and other TC LHIN partners. Three working groups were organized around the main deliverables of the project: Technology Solutions,

Policy and Standards Requirements, and Shared Human Resources.

Once the model was established a business plan was developed to support the implementation process (Appendix A).





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## Project Approach

The project was informed through the following processes:

- Environmental Scan
  - Stakeholder focus group
  - Current state and Needs Assessment survey
  - Literature review
  - Policy, standards and guideline document review
  - Interviews with leading practice organizations
- Gap analysis
- Scan for examples of integrated models within and outside the TC LHIN
- Expert consultation

The environmental scan included an initial stakeholder focus group conducted during the launch of the project. Approximately 40 organizations within the TC LHIN were represented. A literature review was completed under the leadership of Access Alliance (2009) prior to the launch of the project, and was utilized in this report to support the development of the model and assist in the gap analysis

(<http://accessalliance.ca>). The development of the model was also informed through a review of relevant documents relating to standards, policies, guidelines, frameworks, funding structures and integrated systems within and outside the TC LHIN.

In order to understand how an integrated model could be implemented given the unique complexities of the LHIN, structured interviews were organized and conducted with four leading practice organizations: one in Canada and three in the United States.

A survey assessing current state and future needs was developed and distributed to TC LHIN health service providers (HSP). The survey focused on three key areas: technology capabilities, human resource utilization, and policy and standard status. The survey results provided a current state assessment and subsequently informed the gap analysis.

## Environmental Scan

### LITERATURE REVIEW

Access to quality health care is one of the fundamental principles of our Canadian health care system. Yet there is a small and growing body of research demonstrating that Canadians who are not proficient in either of Canada's two official languages experience major health inequities as a result of language barriers. Although addressing health inequities must be considered an ethical and legal obligation, the perceived cost of providing interpretation services represents a major health systems-level challenge. As a result there are serious shortcomings in both the availability and quality of interpretation services within the healthcare system in Canada.

A network of healthcare professionals under the auspices of Access Alliance, commissioned a literature and environmental scan to document the role and impact of interpretation services within the healthcare system. The databases used for the literature search included Pub Med/Medline

and Psychinfo for the years 1997–2009. The environmental scan identified 'grey literature' using professional contacts, websites (e.g., National Council on Interpreting in Health Care, Speaking Together, Hablamos Juntos) and a request to the 'SDOH' (social determinants of health) listserve.

Findings from the literature review and the environmental scan suggest that the provision of professional interpretation services not just contributes to overcoming linguistic barriers in healthcare for both service users and providers but is central to providing high quality health care that is accessible, equitable, timely, safe, and patient centered. The review also found evidence that professional interpretation services can cut overall institutional costs in the long run and improve efficiency, and therefore makes good business sense as well.

The literature review found strong international evidence of the negative impacts of language barriers not just on

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clients but also on providers and healthcare institutions in terms of health care accessibility, quality, efficiency and cost. Existing research findings indicate that lack of professional interpretation services further undermined the accessibility and quality of health care as well as undercut efficiency and increased overall institutional costs.

The absolute costs of failing to address language barriers were not always well-documented; in fact absolute cost-benefit analysis is difficult to undertake when many of the socioeconomic benefits or costs in terms of quality, equity and well-being are intangible and hard to quantify. Nonetheless, findings from existing literature highlight that the numerous benefits that patients, providers and healthcare institutions receive from professional interpretation services outweigh the costs of implementing such services. More importantly, there was a general consensus in the literature that the provision of language access services within healthcare should not be viewed as a separate ‘add-on’ program, but as an essential component of a strategy to meet broader organizational goals including managing risk, improving quality of care, reducing health disparities and establishing partnerships with marginalized communities.

More research is needed on the cost benefit of providing interpreter services, the effectiveness and costs of different types and models of interpreter services, and the identification of strategies to reduce racialized and ethnic health disparities (AccessAlliance, June 2009).

### LEADING PRACTICE INTERVIEWS

Leading and promising practice organizations were identified by experts in the Language Interpretation Service community, based on the organizations’ reputations for successful implementation and operation of interpretation services. The working groups developed a structured interview template and through conference calls with three of the leading organizations in the United States, were able to identify components that could be included in a model for interpretation services within the TC LHIN. All the organizations interviewed are well established and have grown to become large networks with appropriate financial resources. Some of these organizations had third party funding through insurance agencies and Medicaid. The provision of language services is legislated in only one of

the states for the organizations that were interviewed.

To understand the Canadian perspective, we consulted with Winnipeg Language Services. This system operates as a centralized model with access to third party service if an interpreter within the central service is not available. While Winnipeg is a geographically larger area than the TC LHIN, there are a similar number of health providers, and the working groups therefore considered Winnipeg Language Services a useful comparator in developing a model for the TC LHIN.

Generally, a centralized model is by far the most economical and efficient. The organizations interviewed described the model as a seamless system with rapid response to requests. Face-to-face and telephone service were the most utilized and were determined to meet majority of needs. Interpretation through videoconferencing was also utilized in two out of the three American sites. (Appendix B)

### CURRENT STATE & NEEDS ASSESSMENT SURVEY

A survey was developed and distributed to TC LHIN stakeholders in order to assess the current state and inform a gap analysis. The survey, which focused on medical interpretation and remote technology, was designed to collect demographic information about the agencies in the TC LHIN, information related to language human resources, interpretation policies and standards, and technology infrastructure. The survey had 43 questions and required approximately 30–45 minutes to complete.

The survey was distributed electronically to all LHIN-funded agencies which were given two and a half weeks to respond. A letter introducing the survey process was sent to CEOs, as well as a reminder letter one week later. The return rate was 36%, based on 200 provider organizations within the TC LHIN with a total of 67 respondents. Both the hospital and the community health sectors were appropriately represented.

### Demographic Data

The distribution of organizations included teaching hospitals (13%), community hospitals (3%), community support service agencies (22%), community health centres (18%), mental health facilities (13%) and long term care (12%).

Sixty-five percent (65%) of the organizations were considered small to moderate size having less than 150 employees.

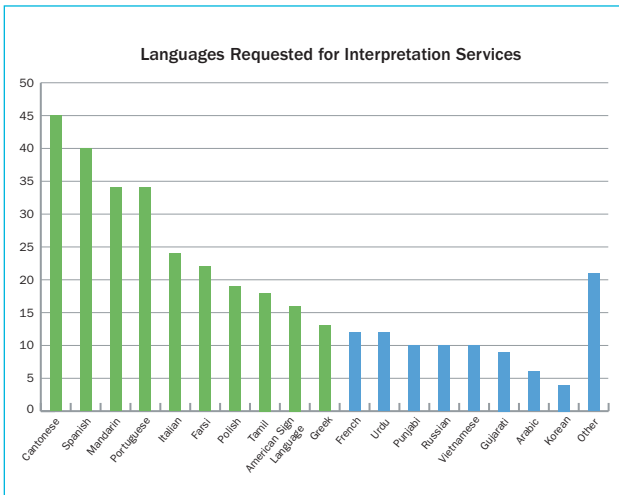
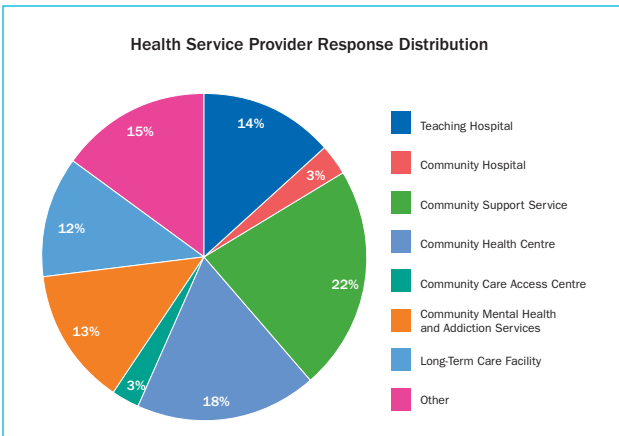
As one of the most ethnically diverse cities in the world, a wide variety of languages are spoken in Toronto, adding to the complexity and challenges of delivering appropriate language services. Given the diversity of languages, it is not surprising that 94% of organizations serve at least some LEP patients/clients.

### Language Data

The 10 top languages identified in the TC LHIN include: Cantonese (46%), Spanish (42%), Mandarin (35%), Portuguese (35%), Italian (25%), Farsi (23%), Polish (20%), Tamil (18%), American Sign Language (17%), and Greek (14%).

Even though the reported need for language services is high, only 55% of organizations actually use professional interpreters to deliver care and in only 25% of the situations that may warrant an interpreter. Access to timely service remains a challenge for organizations. Of the agencies that use interpreters, 31% required same day access and 11% required urgent service. Few organizations have the interpreter intake and dispatch infrastructure to support face-to-face language services in under 24 hours notice, therefore telephone language service would need to be accessed in such cases. Emergency department (8%) interpreter requests are relatively few. This may be related to the difficulty in accessing face-to-face interpreters on an urgent basis. Only a small portion (36%) of interpreter requests is required for outpatient clinics, specialty clinics and inpatient units where pre-planning is realistic. The top five clinical encounters in which interpreters are able to be pre-booked include initial assessments (53%), counseling (27%), consent (19%), follow-up appointments (19%), and for explaining treatment options (17%). There is evidence that emergency situations have very little interpreter resources available when this should be a time when accurate communication is crucial. Some U.S. States legislate the use of interpreters for emergency situations and urgent psychiatric consults.

Limited language information about patient/client populations is collected by some health care organizations. Almost 77% of organizations do not collect any form of language information. Forty-two percent (42%) of the organizations that collect language information (language



spoken at home, preferred language, country of origin, ethnicity, primary language or need for interpreter of a given language) do so at points of intake and document this information in the patient chart.

Many of the surveyed organizations do not collect data related to the need and use of language services within their organizations. Sixty percent (60%) do not track the number of interpreter requests and 40% do not track how many requests are filled or unfilled. Lack of data creates barriers to making decisions about staffing, budgeting, and language needs. For those who do collect data about number of requests and filled requests, 26% of organizations meet less than 75% of their requests which may mean that some LEP patients/clients do not have equal access to information.

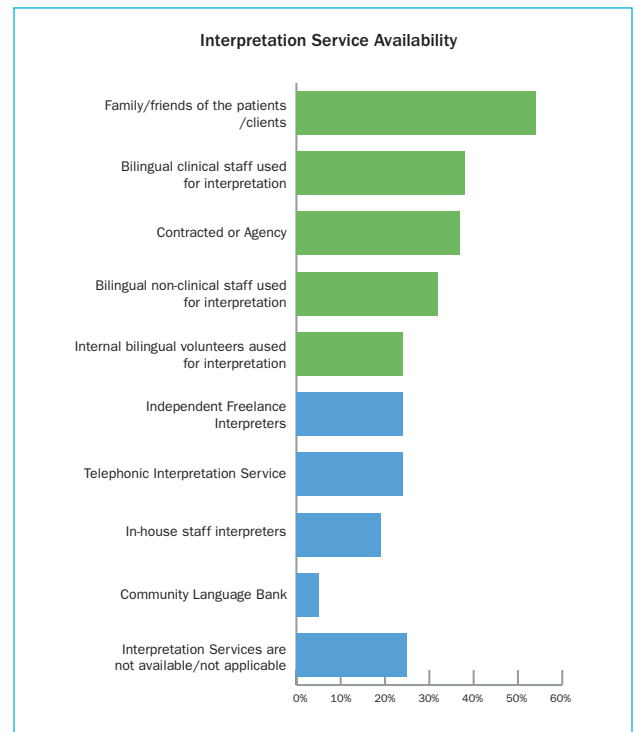
### Interpreter Human Resources

Professional interpreters are generally affiliated with the larger urban teaching hospitals. Smaller organizations do not have the infrastructure or the resources to support staff medical interpreters and are dependent on other ways to ensure effective communication. Telephone language service would be the next best option to face-to-face for interpretation, yet only 22% of organizations both large and small, utilize telephone interpreter services. Sixty percent (60%) of smaller organizations use clinical and non-clinical bilingual staff and 32% count on family and friends of the LEP client. Those organizations that use bilingual volunteers and clinical and non-clinical bilingual staff provided little if any training with approximately 90% having no training at all. Evidence reveals that using untrained persons to interpret can lead to adverse effects, medication error, misdiagnosis, inappropriate treatment, inappropriate admissions, poor adherence and lack of follow-up care due to inaccurate interpretation, lack of understanding how to interpret medical terms and omitting of sensitive information.

Inconsistencies in baseline qualifications were identified for those organizations that employ professional medical interpreters. Few have college level interpreter training (8%) or recognized credentials (14%).

### Challenges

When asked what barriers organizations face in providing interpreter services, 64% identified cost/reimbursement as their main concern, while 35% identified challenges in



understanding the specific language needs of the patients/clients, likely related to inconsistent data collection. Many organizations cite challenges associated with the workload of health care providers, suggesting staff believe they do not have enough time to coordinate services (28%), organizations lack training resources to teach staff how to work with interpreters (25%) and staff in general lack awareness of language needs (20%).

At an initial focus group session, TC LHIN stakeholders identified inconsistent agency policies, standards and guidelines as a concern. Approximately 35 to 45% of organizations have staff-related guidelines, process-related guidelines, standards, policies and procedures related to language services with around 20% of other organizations in the process of developing documents or a plan to develop them. A consistent set of standards, policies and guidelines recommended centrally would decrease the amount of time spent on development as well as help eliminate duplication.

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## **Funding**

Funding for language services differs across health sectors and among providers with 35% supporting the service at their own discretion through their global budget and 37% having no formal funding structure. A small percentage of organizations fund language services through foundations and corporate sponsorship. For those who reported having budgets for language services, the expenses range from \$3000 to \$260,000. Across organizations, Interpretation services are operated out of a variety of departments and programs, including Quality & Risk Management, Human Resources, Clinical Programs and Patient Support Services. There is an even distribution between centralized (coordinated by a specific department) and decentralized (coordinated at the program level) language services depending on the organization.

## **Document Translation**

Many organizations use translated written materials to support patient care. Sixty percent of agencies translate their own materials. Materials are translated using external translation agencies (70%), in-house translators (38%) and other (29%). Ninety-one percent of agencies have no budget for translating documents. Sharing of translated materials through a central repository and negotiating a single contract for translation for all agencies could be a cost-saving strategy.

## **Technology**

In order to support particular technology solutions to interpreter services such as video interpretation, organizations would need a minimal level of information technology available. Of those who completed the survey, 20% did not have the skilled IT resources to respond to technical questions.

A large percentage of the organizations have a computer network that can potentially be used to connect communications devices or computers in order to access the Interpretation Service. Eighty-six percent of organizations have a Local Area Network (LAN—wireless or wired) with 60% able to expand their IT infrastructure to add additional wired or wireless LAN devices. The majority of respondents had access to the internet or can use eHealth Ontario's ONE network.

More than half do not have prior experience in deploying Voice/Video over Internet Protocol (VOIP) and applying Quality of Service to this type of traffic if it becomes necessary. It is likely that many organizations will require additional IT expertise to help with implementation/configuration. The few that have the expertise appear to have a suitable IT infrastructure. Sixty percent of organizations use either internal, external or a combination of Information Technology resources, while only 30% have a specific IT budget. The readiness of organizations to embark on a centralized technology solution to interpretation for their patients/clients varies. Some smaller organizations would need technical assistance in order to participate. (See Appendix C for Survey)

## Vision

All LEP persons seeking health services across sectors will receive a comparable level of service as provided to those persons who speak English. This requires the creation of a system to ensure that LEP persons have equitable access to safe, responsive, understandable, and effective healthcare

services. More broadly, this service is intended to enhance access to quality health care for underserved individuals, and promote fundamental improvements in the health status of Torontonians.

## Guiding Principles & Criteria

The following guiding principles were identified to guide the creation of a language services model for the TC LHIN:

- Centralized
- Efficiency
- Effective
- Easily accessible by provider and patient/client
- Responsive
- Consistency
- Seamless (no matter where a person is receiving care, there will be the same standard for language services)
- Patient/Client-centred
- Aligned to meet needs of diverse clinical situations
- Multi-faceted strategy optimizing available technology
- Integrated with multiple levels of government

In order to develop a Language Services Solution, the following criteria must be met:

A Centralized Language Service model that

- is structured and comprehensive;
- has consistent policies and procedures in place;
- includes regular, systematic assessment of the language needs of people in the service area;
- uses a community needs assessment to determine resource utilization and to identify the types of oral language assistance required;
- establishes training and competency protocols for interpreters (orientation) and providers (working with interpreters); and
- establishes an audit and sustainable evaluation system.

Based on the information gathered through the environmental scan, literature review, survey, interviews and focus groups, the project team developed a recommended a centralized integrated interpretation model for providing a sustainable and expandable interpretation service within the TC LHIN.

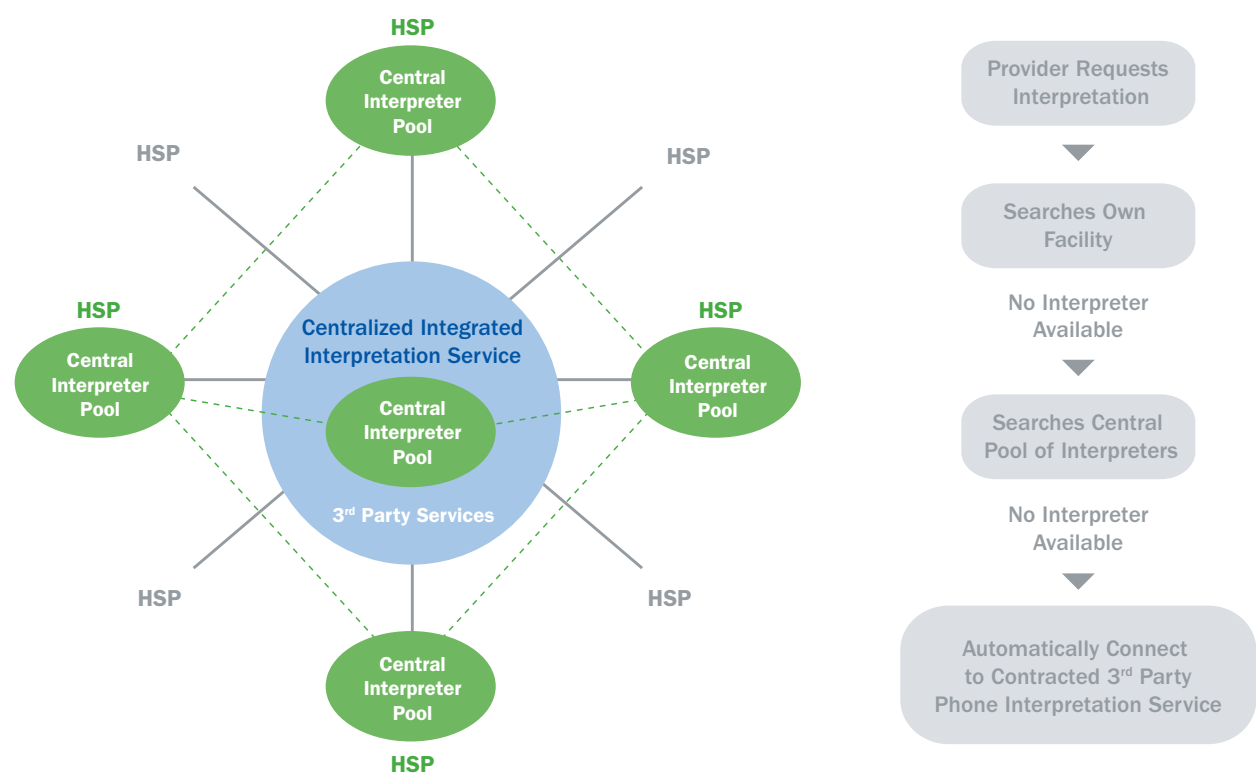


# Centralized Integrated Interpretation Service (CIIS)

In order to accommodate a wide variety of health care agencies that face challenges in meeting the access needs of LEP patients, a Centralized Integrated Interpretation Service (CIIS) is recommended. Advantages of a centralized and integrated network include: consistent policy, standards and guidelines across the LHIN, more effective sharing of information and resources, better coordination of program development and service delivery, improved performance management system, implementation of consistent standards, training and testing.

The Centralized Integrated Interpretation Service (CIIS) model will provide interpretation and document translation services to the TC LHIN through a centralized pool

of interpreters. A variety of modalities for interpretation including face-to-face, telephone and video conferencing will be utilized. The pool of interpreters will be managed through a centralized scheduling/booking system. Telephone services would be triaged through a web-based routing system to ensure fast and efficient service using one access number. Central to the model is a health service provider (HSP) that is assigned to be the host organization for the CIIS. Access to the pool of interpreters will require organizations to subscribe as members. Members will be required to implement standardized language policies, procedures and will be required to collect and report data necessary to support and sustain the system.

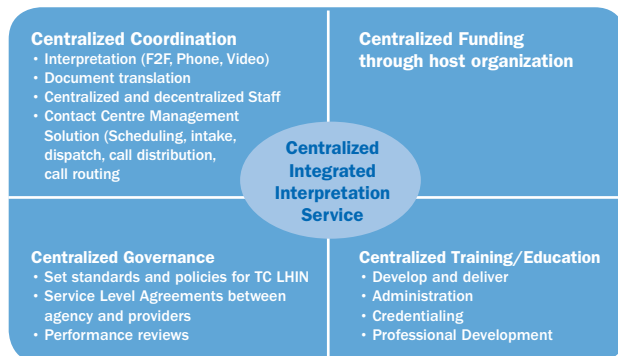


The CIIS will employ the services of a third party interpreter service, should an interpreter within the central network not be available. The use of this third party provider will be integrated into the routing technology, such

that a user will be automatically transferred accordingly if the system is not able to find an available interpreter within the CIIS. To the end user, this process will be seamless and will require no action on their part.

The CIIS model is built on four key components:

- Centralized Coordination
- Centralized Governance
- Centralized Funding through a host organization
- Centralized Training/Education



## CENTRALIZED COORDINATION

Centralized coordination within this model refers to the coordination of all services (face-to-face, phone and video interpretation and document translation) and interpreter staff by a host organization regardless of physical local location of interpreters.

### Staffing & Services

Within the host organization, there will be a centralized pool of interpreters who are available to be contracted for face-to-face interpretation to organizations that subscribe to the service. Recognizing that some organizations have greater needs for frequent face-to-face interpretation, decentralized pools of interpreters will be physically located within those respective organizations to meet their needs. During lower utilization periods, these decentralized interpreters will be available to provide phone interpretation to other organizations within the network. All interpreters are required to spend a specified amount of time on remote technology, regardless of their physical location. Language compliment of interpreters is based on the volume of need.

Coordination of services and staff will be supported by a contact centre management technology solution that will manage scheduling, intake, dispatch, call distribution and call routing.

A web based Contact Centre Management Solution will enable:

- Tracking of requested needs in real time;

- Tracking of an interpreter's geographic location throughout the day;
- Tracking of completed cases ;
- Queuing of phone call requests;
- Collecting of demographic and detail data of all staff and non-staff medical interpreters;
- Generation of reports.

## Data Collection

Centralized coordination will enable the collection of data, which is necessary for future planning. Data will inform the need for number, location and type of interpreters based on key indicators including:

- Percentage of patients/clients served /requiring interpretation at each agency;
- Number of requests filled;
- Number of languages used at each agency.

## Monitoring and Evaluation

Data collection will also enable on-going monitoring and evaluation to ensure service effectively meets patient/client language needs. The CIIS will annually review and update the language access plan as necessary. Data collected centrally will also allow for the on-going tracking of the predominant non-English languages spoken in the individual agencies, ensuring resources continue to be appropriate to meet the population needs. Additionally, patient satisfaction can be monitored for different languages and delivery modalities.

## Increased access to translated materials

Part of the mandate for the CIIS is the development and maintenance of a central repository for translated materials. Central organization and control for outsourcing of materials to be translated will ensure efficiency, save on costs and decrease duplication. This will also encourage the use of evidence-based health literacy standards in the creation of plain-language patient materials.

## CENTRALIZED GOVERNANCE

For the CIIS model, centralized governance will include the implementation of consistent standards and policies which includes the process for performance review of the interpreters within the system. The host organization will also negotiate all service level agreements with member organizations.

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### **Stakeholder Oversight Committee**

The governance structure will include a Stakeholder Oversight Committee to oversee the quality of the network and to ensure the needs of TC LHIN health care providers and their patients/clients are being met. The oversight committee will meet on a quarterly basis to assess the level of services provided to the various sectors, and ensure the network has the resources necessary to support language needs provided by third party providers who will supply a small percentage of services.

### **Service Level Agreements**

All member organizations will be asked to commit to an accountability agreement with the CIIS. This would make certain a consistent standard across the LHIN. Agreements would ensure reporting of language and ethnicity in the patient profile, allow for benchmarking linked to demand data, outline the organizations' responsibility to provide local staff interpreters with space and equipment and ensure interpreters are orientated to the setting. Organizations would be obligated to support Cultural Competence Training for their health care staff.

### **Corporate Contracts**

The CIIS will oversee corporate contracts related to language services including third party interpreter service providers; translation of written materials; testing of language proficiency and/or interpreter skills; and will offer cultural competency training programs to ensure quality assurance and cost benefit for all.

### **Performance Improvement**

Performance and quality of interpreters and the services delivered will be monitored centrally. This will allow for the promotion of a corporate-wide performance review system, allow for capturing language specific data on barriers, and focus on reducing risks related to LEP patients/client through advocacy.

### **CENTRALIZED EDUCATION/TRAINING**

The centralization of education and training refers both to those providing service, and the end users of the service including the health care provider and the patient/client.

### **Health Provider Training**

The CIIS would make available standard education modules in cultural competence training for organizations that do not necessarily have the infrastructure to support education and professional development of staff. (See appendix D). The service would allow sharing of tools to enhance the use of interpreters (See appendix E) and ensure interpreters within the network are trained and tested to maintain their competency.

### **Quality Control of Interpreters**

Given there are no provincial or national standards for basic qualifications of medical interpreters, it is essential to maintain a standard of language services across the TC LHIN. The CIIS would set criteria for the testing of interpreters to ensure quality of services, (See appendix F), set guidelines for the consistent collection of interpreter services data for central reporting and share tools to alert patients/clients and staff to language access programs and interpreter services.

### **Quality Indicators**

The current decentralized and ad hoc system for language service does not easily allow for the monitoring of the quality of services provided. The CIIS will set quality indicators for services provided including:

- Timely availability of language services;
- Introduction and role explanation by interpreter;
- Accurate transmittance of information;
- Clarification by interpreter;
- Clarification of cultural beliefs;
- Identification of clients'/patients' further needs by interpreter;
- Overall rating of interpreting services;
- Improvement in staff work environment.

### **Sustainability**

The CIIS would advocate for language policy integration into each member organizations' general policy on diversity to facilitate a culture of sensitivity and awareness of issues related to language barriers. Sustainability will be realized by interpreter services being an integral component of practice not having to rely on local champions to identify needs. The CIIS will utilize data to advocate for legislated commitment and designated funding.

## Policies & Standards Recommendations

This recommended policy framework will enable health service organizations to provide linguistically accessible services.

### Policy Statement

Health care organizations will ensure that optimal communication occurs between healthcare practitioners and limited English proficiency patients/clients/families through the provision of competent interpreter services at

no cost to the patient/families. Patients/clients will receive required services provided in their preferred language, in a timely manner that is respectful and culturally appropriate.

### Policy Compliance

Compliance with this policy requires development of systems and processes at the level of the Toronto Central LHIN, at the individual member organization level and at the service delivery level within and across sectors.

## COMPLIANCE REQUIREMENTS

SYSTEMS LEVEL	ORGANIZATIONAL LEVEL	SERVICE DELIVERY LEVEL
<p>Responsible for:</p> <ul style="list-style-type: none"> <li>• Support of funding structures to facilitate language access strategies</li> <li>• Embedding requirement for organizations to comply in accountability agreements</li> <li>• Linking accountability requirements to accreditation frameworks</li> <li>• Providing population level data to assess need and determine trends</li> <li>• Support development of evaluation frameworks</li> <li>• System monitoring (linked to equity plans, etc.)</li> </ul>	<p>Responsible for:</p> <ul style="list-style-type: none"> <li>• Tracking of patient language at intake to establish demand</li> <li>• Development of procedures and protocols to determine language needs of patients/clients and guide service delivery</li> <li>• On-going staff training across all disciplines regarding culturally and linguistically appropriate service delivery.</li> <li>• Inclusion of trained language interpreters as part of the health care team by staff across all disciplines</li> </ul>	<p>HIN National Standard Guide for Community Interpreting Services endorsed by organizations as minimum standard in terms of interpreter qualifications, skills and competencies; role and responsibility of interpreters (included interpreters standards of practice and ethical principles)</p>

## COMPLIANCE REQUIREMENTS AT SYSTEMS LEVEL

### Support of funding structures to facilitate language access strategies

- development of a funding formula linked to demand data

### Providing population data to assess need and trends affecting service delivery

- The TC LHIN will work collaboratively to support HSPs analysis of population data such as census figures, health utilization reports, immigration levels to establish clear snapshots of patient groups, trends, gaps in service responses.

### Embedding a requirement for HSPs to comply in accountability agreements

- Could include: reporting of language and ethnicity patient profile, minimum benchmarks linked to demand data.

### Linking accountability requirements to accreditation frameworks

- The TC LHIN can work collaboratively with accrediting bodies to establish standards and indicators related to responsiveness to language access barriers faced by patients/clients.

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### **Support development of evaluation frameworks**

- Identification of objectives and indicators of success
  - Financial – economies of scale, reduction of cost
  - Health indicators – e.g. linked to: miscommunications and medical errors, delay or denial of services, issues with medication management, overutilization of diagnostic procedures and underutilization of preventative services.

### **System monitoring**

- Integrate monitoring processes into current systems (ie. linking to Organizational Equity Plans)

### **COMPLIANCE REQUIREMENTS AT THE ORGANIZATIONAL LEVEL**

#### **Tracking of patient language and ethnicity at intake to establish demand**

- Language and ethnicity fields will be added to intake data collection processes (e.g. fields required upon registration) to identify characteristics of user groups as they pertain to language access needs
- This data will be shared centrally and regionally to establish service utilization
- Service provision will be evaluated against patient linguistic profiles.

#### **Development of procedures and protocols to determine language needs of patients/clients and guide service delivery**

- Communication regarding availability of language services to all patients/clients and family members (signage, intake paperwork, etc.);
- Translation of vital documents in top five to eight languages;
- Language assessment tools at intake and other points of contact;
- 24/7 access to services across all points of service; use of technology as appropriate;
- Clear location of accountability within hospital management to ensure practice guidelines and evaluation;
- Clear guidelines are adopted regarding where to use interpreters and appropriate service modalities ;

- Establish policies, practices and procedures on providing language services Clear service framework established (in-house staff, contracting out, and casual pool) until such a time as a system-wide solution is available across the health sector.

#### **On-going staff training across all disciplines re: culturally and linguistically appropriate service delivery**

- Implement practice standards on the skills, behaviors, ethics, and linguistic knowledge necessary for competent care and interpretation;
- Train staff and volunteers on the provision of language services and cross-cultural communication (or cultural awareness);
- Develop and or adopt adaptive and flexible learning modules easily available for all staff to access (e-resources, webinars, etc);
- Provide Incentives for staff attending training (including students, residents, etc.).

#### **Staff across all disciplines will include trained language interpreters as part of the health care team**

- Clear standards regarding minimum training and experience requirements for interpreters will be adopted (e.g. HIN Guidelines);
- Guidelines regarding use of bilingual staff and casual interpreters will be developed and enforced to the extent possible (e.g. discontinued use of untrained bilingual staff, volunteers or family members for health sensitive matters – never children under 18 years of age);
- Ensure that staff document the use of an interpreter in the patient's chart including the full name of the interpreter used (regardless of whether is bilingual staff, trained volunteers, family members etc);
- Implement QA measures to include performance feedback evaluations for interpreters and patient satisfaction surveys on the use of interpreter services.

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## Human Resources Recommendations

Currently, the human resources plan for interpreters is unique to each hospital and varies in its scope, coordination and standards. A number of hybrid models are used to meet the needs of each organization's patients/clients. Only three large teaching hospitals in the TC LHIN employ medical interpreters on staff. This enables these centres easier access to services. A limitation factor includes the 24 to 48-hour booking time for face-to-face services, which does not meet urgent or same day service requirements. Some organizations have interpreters on rosters and also contract interpreters from third party services. Telephone interpretation service is primarily delivered through third party service for most organizations that utilize this technology.

Bilingual staff or volunteers are used for interpreting in some organizations. Currently there are no standards to ensure ability in interpretation. Fundamental ethical aspects of healthcare between providers and patients/clients may be compromised when bilingual staff or volunteers who have not received health care interpreter training are asked to interpret. At high risk also are patients/clients who use family members and friends as interpreters. Risks include among others, loss of confidentiality, potential misdiagnosis, potential for non-valid informed consent and potential harm. These consequences increase health care costs and liability, and lead to poor health outcomes. Recommended are the following standards:

### Family Members/Friends

- Not to be used for communicating health information;
- Can be used for simple communication (ie. directions, way-finding) and non-critical activities (ie. menu selection).

### Clinical & Non-clinical Bilingual Staff & Volunteers

- Language tested if available (\*for emerging languages, testing will be required when available-appendix G);
- Implement Quality Control standards including recommendations for number of hours interpreting on a monthly basis to maintain competency or re-testing if not meeting the requirements (Non-clinical unionize staff may not be available to interpret due to their collective agreement. Each organization would need to clarify);

- Not required to be trained and tested when a bilingual professional is caring directly for the patient (two-way communication) but must ensure they are being understood by the patient/client according to their professional standards.

### Professional Interpreter (staff or freelance)

- Requirements include university degree (includes international university), preferably in languages or related field and 100 hours of training and interpreter experience in the field or college certificate in Interpretation and documented experience in the field;
- Medical terminology course if not included in the certificate program;
- Language tested if available\*(Appendix G);
- Must be used for capacity assessments, court mandated assessments;
- Strive to have face-to-face interpretation for situations of psychiatric crisis, complex urgent critical situations, utilize telephone interpretation initially if face-to-face not readily available;
- Quality control standards to be implemented including recommendations for number of hours interpreting on a monthly basis to maintain competency or re-tested if not meeting the requirements;
- Interpreters will take part in professional development opportunities to maintain competency (appendix H).

### Training for Bilingual Staff & Volunteers

In Canada there is no accredited program for staff and volunteers to undergo in order to ensure a foundational level of competency. There are programs in the United States that have been effective such as Bridge the Gap, which was developed and implemented by the Cross Cultural Health Care Program ([www.xculture.org](http://www.xculture.org)). This program includes a train the trainer component that allows for licensing to deliver the training for staff and volunteers within their own organization. Similar programs in Canada have been adapted by various organizations. Although this is a gap and there would need to be some program development, it would be realistic to implement such a program in Ontario and eventually Canada, to support the implementation of a Central Integrated Interpretation Service.



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### **Cultural Competency Education for Providers**

Cultural competence refers to an ability to interact effectively with people of different cultures. Cultural competence comprises four components: (1) awareness of one's own cultural worldview, (2) attitude towards cultural differences, (3) seeking knowledge of different cultural practices and worldviews, and (4) utilizing the knowledge to enact cross-cultural skills. The term culture is representative of an individual's values, norms and traditions, and these in turn effect how individuals of a particular group perceive, think, interact, behave, and make judgments about their world. The literature reveals that a lack of cultural understanding can potentially have negative consequences in the delivery of health care.

Organizations engaged in leading practice for diversity have a defined set of values and principles and demonstrate behaviours, attitudes, policies, and structures that enable them to work effectively with diverse cultures. This is facilitated through cultural competence education for staff. It is important for health care providers to develop cultural competence resulting in an ability to understand, communicate with, and effectively interact with people across cultures.

Cultural competency within the health care setting has been identified as a necessary component of effective and equitable care delivery for LEP patients/clients and families. In order to support the proposed Centralized Integrated Interpretation Services model across the LHIN it is recommended that agencies commit to cultural competence training for their staff with the following key components:

- the impact of language barriers on patient care,
- when and how to call for an interpreter,
- how to work with on-site and telephone interpreters,
- risks associated with using friends and family members as interpreters,
- the dynamics of the triadic relationship (patient-interpreter-staff/provider),
- ethical and legal issues, and
- the negotiation of cross cultural communication issues in health care.

There are a number of organizations delivering this education which can be adapted for a variety of settings (Appendix D).

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## Technology Solution Recommendations

The current demand for interpretation services in health-care settings exceeds the capacity of qualified interpreters within the TC LHIN. This situation is not unusual in large cities with a high proportion of immigrants with limited English proficiency, and given the particularly high linguistic diversity of Toronto.

Traditional, face-to-face interpretation is the Gold Standard, but unpredictable wait times and travel take up most of the interpreter's day, resulting in a maximum of four to six patient face-to-face encounters per day.

Remote technology has been successfully implemented in other jurisdictions to increase the capacity of language services in hospitals, community centres and smaller medical settings. Remote technology is a broad term referring to telephone and video conference interpretation, where the interpreter is stationed in one location and the users (service providers and patients/clients) access their services from another location, locally or long distance, usually on demand. By eliminating wait and travel time, phone and video interpreters can provide services to 25 to 30 patients/clients per day, significantly reducing the cost per patient encounter.

The Centralized Integrated Interpretation Service model proposed for the Toronto Central LHIN incorporates remote technology to increase the capacity of the local pool of qualified medical interpreters. Building on best practice programs in the U.S., a hybrid model of face-to-face, phone and video interpretation, ensures optimal access to language services. Where available, face-to-face interpreters will be dispatched for sensitive cases such as

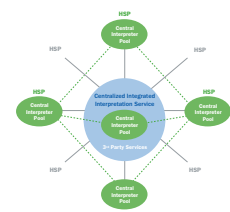
diagnosis discussions, capacity and cognitive assessments, family meetings, mental health services, palliative care, and emergency triage levels I and II. For routine clinical visits, medical imaging and inpatient care, providers will access on-demand remote interpreters. The automated system searches first for local interpreters, and if none are available, the call is routed to an external vendor. The process is seamless and occurs automatically in seconds.

The proposed model envisions a host organization as the hub of the system, located within one of the partner organizations. Several other hospitals or "satellite" facilities, together with the partner organizations, comprise a network.

Intake for booked appointments is managed through a centralized workforce management and dispatch system. HSPs that do not have on-site interpreters will access language services from the host or satellite organizations through remote technology according to the organization's capacity. This non-profit interpretation service model is affordable, expandable and consistent with the project goal of getting the interpreter to the patient, every time an interpreter is needed.

In order to realize the Centralized Integrated Interpretation Service across the TC LHIN, a phased approach for implementation has been outlined. The implementation of the shared language services model will take between 21 and 30 months to complete and is divided into four phases. The phased approach ensures the technology functionality is optimal using targeted organizations initially and is gradually expanded to a growing number of agencies as they are prepared to connect to the network.

## Implementation Strategy

Prep Phase I	Prep Phase II	Implementation Phase 1	Implementation Phase 2	Final State
3 to 6 months	6 to 12 months	6 months	6 months	
<b>In Scope:</b> <ul style="list-style-type: none"> <li>Conduct readiness assessment/issue RFP to select host organization</li> <li>Establish centralized service within the selected host organization</li> </ul>	<b>In Scope:</b> <ul style="list-style-type: none"> <li>Establish stakeholder oversight committee consisting of TC LHIN providers</li> <li>Hire Project Manager</li> <li>Identify phase 1 organizations</li> <li>Issue technology RFP based on organizational readiness of phase 1 organizations</li> <li>Call Centre Management solution (call routing, web-based appointment scheduling hardware)</li> <li>Negotiate 3<sup>rd</sup> party service contract</li> <li>Build template for service agreements with participating HSPs</li> </ul>	<b>Start with:</b> <ul style="list-style-type: none"> <li>~ 3 HSPs (w/internal interpreters)</li> <li>~ 2 HSPs (w/o internal interpreters)</li> </ul> <b>In Scope:</b> <ul style="list-style-type: none"> <li>Roll out technology</li> <li>Implement call centre with key languages (unscheduled, immediate)</li> <li>Introduce components of standards and policies to participating HSPs re how to work with interpreters, when to use phone, etc.</li> <li>Collect data to inform phase 2</li> <li>Evaluate service agreement template and modify as needed</li> </ul>	<b>In Scope:</b> <ul style="list-style-type: none"> <li>Expand network of participating HSPs</li> <li>Implement remaining standards and policies</li> <li>Pilot video conferencing</li> </ul>	 <ul style="list-style-type: none"> <li>Fully functional and integrated centralized interpretation service offering interpretation via: <ul style="list-style-type: none"> <li>Face-to-face</li> <li>Phone</li> <li>Video conferencing</li> </ul> </li> <li>Fully implemented Standards and policies</li> <li>Fully implemented HR policies</li> <li>Sector expansion</li> <li>Offer free-for-service to other sectors</li> </ul>

### Preparation Phase I

It is anticipated that this phase will take approximately three to six months to complete. In this phase, a readiness assessment/RFP process needs to take place to select a lead organization that is ready and able to host the service. At a minimum, eligible organizations must currently have in place:

- an in-house interpretation services department with staff interpreters,
- a robust IT network with an available support department, and
- a human resources department

### Preparation Phase II

It is anticipated that this phase will take approximately six to 12 months to complete. In this phase, the host organization will be responsible for establishing the stakeholder oversight committee that will consist of members from providers across the TC LHIN. A project manager will need to be hired to manage the implementation of the model, including:

- Selecting the organizations that will be part of the initial implementation of the model (approximately three Health Service Providers (HSPs) that have their own interpretation staff and 2 HSPs that do not have their own interpretation staff);

- Assessing the Phase 1 organizations for their technological readiness;
- Issuing an RFP for the technology solution based on the organizational technological readiness assessment;
- Issuing an RFP for the call centre management solution that will be able to support call routing and web-based appointment scheduling;
- Negotiating 3rd party service contract(s) when service cannot be managed by the new network; and
- Developing a template for service agreements between the host organization and the participating HSPs.

### **Implementation Phase 1**

It is anticipated that this phase will take approximately six months to complete. In this phase, technology will be rolled out to the first group of participating HSPs.

The call centre will be set up with the key languages and will include providing service for unscheduled, immediate requests for interpretation. To guide the use of this central service, including how to work with interpreters, when to use the phone for interpretation, etc., the applicable components of the standards and policies will be introduced. As the service is rolled out and functioning, utilization data will need to be collected to inform expansion and growth of the network. Finally, the service agreement template will be evaluated and modified as needed.

### **Implementation Phase 2**

At a minimum, this phase will take six months to implement the remaining standards and have the system fully functioning.

## **Quality Health Related Indicators**

The following are proposed quality indicators for monitoring and evaluating the effectiveness and efficiency of the services provided by through the Centralized Integrated Interpretation Service:

- Create systems for monitoring LEP patient satisfaction including:
  - Accessibility of interpreter services;
  - Quality of interpreter services;
  - Patient satisfaction surveys, (ie. NRCPicker in different languages).
- Cost assessment;
- Medical errors related to miscommunication;
- Issues with medication management;
- Delay or denial of service;
- Over-utilization of diagnostic procedures and under-utilization of preventative services.
- Develop mechanisms for annual reassessment of community language needs;
- Develop and publicize grievance reporting procedures for LEP patients/clients in the commonly encountered languages of the hospital, including provisions for patients/clients who feel they have not been provided with adequate interpreter services.

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## Funding Structure Recommendations

In order to sustain the service and facilitate the potential to expand across the TC LHIN and potentially the province with the goal of servicing other sectors outside of health care, the model proposed is a hybrid of a centralized funding model. The proposed funding structure entails the Central Integrated Interpretation Service (CIIS) be organized within the infrastructure of a host organization. The CIIS would be able to utilize the services and infrastructure of existing departments within the host organization including: Human Resources, Finance, Occupational Health & Safety, Information Technology, and Quality and Risk. Similar examples of this model would be Safe Kids Canada and the Ontario Poison Centre which are hosted within the SickKids organization.

The host organization would be responsible for the operations and administration of the CIIS.

### Advantages:

- Cost saving by utilizing existing business structure;
- Accountability of the success of the service would be within the host organization;
- Funding allocated to one organization or source to improve accountability and transparency;
- User-friendly access to language services for all sectors;
- Minimized capital costs by using existing infrastructure.

### Service Agreements

Currently all agencies negotiate their own contract with third party providers (i.e. telephone language services, contracted agency interpreters). The CIIS will allow for one contract to be negotiated across the TC LHIN. Third party providers will be selected on their ability to meet the needs of the patient population the most economically. If all languages are not available with one provider, it may be necessary to have more than one contract.

Service agreements will also be negotiated with the hospitals that have professional interpreters on site. It is necessary that the hospitals have their needs met with the availability of face-to-face interpreters and also support the network. There would be two options for the staff interpreters:

### Option A:

On site interpreters will be employed by the CIIS regardless of their geographical location. The CIIS will provide the following:

- Liability Insurance
- Professional Development
- Orientation to the role
- Performance Appraisal

The hospital will provide:

- Site orientation
- Legislated education (WHIMS, Occupational Health & Safety, Fire Safety)
- Desk, phone, computer, space

### Option B:

On site interpreters will be employed by the member organizations and contracted out to the Central Integrated Interpreter Service. Service agreements with the organizations will ensure the interpreters spend an agreed to amount of dedicated time on the telephone service to support the system. Interpreters will be paid through the Central Integrated Interpretation Service.

## Conclusion

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Equity in health is the absence of systematic disparities in health between groups with different levels of underlying social advantage/disadvantage. Language barriers create disparity to an equivalent level of healthcare as those who are English speaking. A Centralized Integrated Interpretation system in the Toronto Central LHIN is one solution to breaking down barriers and facilitating optimal health for all Torontonians. Successful implementation could have broader effects in shifting national policy toward greater social justice in the health of Canadians.





BUSINESS CASE FOR CENTRALIZED INTEGRATED INTERPRETER SERVICE

Background

The proposed centralized interpretation model is based on the concept that the strategic sharing of interpretation resources will ultimately reduce costs, increase efficiency and improve equitable access to services across the Toronto Central LIHN. To validate this hypothesis a model was developed that compared the 2009/2010 provision of interpretation services across five unique health facilities with the proposed model of shared delivery to determine the fiscal and access implications.

In order to better understand the variability in current spending and demand for interpretation services, information was utilized from a large paediatric teaching hospital, a large adult teaching hospital, an organization specializing in mental health, a community hospital and a community health centre. The information gathered included the composition of internal resources, the top languages requested, the frequency of these requests, the manner by which they were filled and the total cost of fulfilling these requests.

Analysis

Comparing the top languages revealed that there was a significant amount of variation in the demand for specific languages driven by demographics and the focus of the Health Service Provider (HSP). The delivery of services and the cost associated with the services also varied significantly across institutions and appear to be influenced by the organizations budget and utilization of internal and external resources.

	# OF REQUESTS FILLED	METHOD BY WHICH REQUEST WAS FILLED
Large paediatric teaching hospital	8035	internal and external resources
Large adult teaching hospital	12,818	internal and external resources
Mental health organization	2718	external resources
Community hospital	3572	external resources
Community health centre	260	external resources

Based on in-house metrics it was determined that the ratio for the provision of interpretation services by either phone or in person across the top languages was approximately 1:2; such that for every 15 requests 5 were fulfilled using phone services and 10 were fulfilled using face-to-face engagements.

The average salary for an interpreter is approximately \$65,000 including pension and benefits. The workload capacity of an interpreter was estimated based on the assumption that an interpreter theoretically should be able to fulfill either six face-to-face visits or 15 phone sessions per day. Using a five day work week and a 75% productivity level to reflect vacation, holidays and sick days, it was estimated that a single interpreter should be able to fulfill 1,170 face-to-face visits or 2,925 phone sessions annually.

INTERPRETER CAPACITY	PHONE	VISIT
1 day	15	6
1 year	3900	1560
0.75% Efficiency	2925	1170
Interpreter Salary	65000	65000
Cost per request	\$22.22	\$55.56

Based on this data, the cost to fulfill a request is approximately \$22.22 per phone session and \$55.56 per face-to-face visit, which is significantly less than any single institution is currently paying.

Comparing the above capacity with each institution's existing requests also brings to light that no single institution has the demand for any one language bundle to warrant the funding of a single full-time interpreter, which supports the proposed hypothesis of funding for shared centralized interpretation services.

COMBINED TOP LANGUAGES	# OF REQUESTS	REQUIRED VISITS	REQUIRED PHONE
Cantonese	4288	2859	1429
Spanish	4227	2818	1409
Portuguese	3786	2524	1262
Mandarin	2543	1695	848
Vietnamese	1503	1002	501
Italian	1023	682	341
Polish	883	589	294
Tamil	1012	675	337
Korean	607	404	202
Punjabi	356	237	119
Russian	556	371	185
ASL	775	516	258
Arabic	379	253	126
Farsi	492	328	164
Urdu	327	218	109
Turkish	243	162	81
Hindi	195	130	65
Greek	194	129	65
Serbian	180	120	60
French	141	94	47
Other	3333	2222	1111
Total	27042	18028	9014

The proposed model was evaluated by creating an optimal internal resource structure to meet the existing demand of the surveyed institutions. The top 20 language requests for the participating organizations were sorted by frequency. The combined top languages were then ranked and the associated requests were then split into phone and visit requests using the observed phone:visit ratio.

To realize greater efficiencies, the top languages were aggregated into the following language bundles which are often served by a single interpreter and that surpassed the established service provision for a single interpreter: Mandarin/Cantonese, Spanish/ Portuguese/ Italian/ French, Vietnamese, Punjab/Urdu/Hindu.

As the proposed model requires a single interpreter for each language bundle to manage a phone line full-time, the optimal number of staff was derived by comparing the capacity of various staffing mixes and the estimated demand to ensure that all internal requests could be filled and that there was minimal excess capacity. It should be noted that any excess capacity that does exist could be easily utilized by additional HSPs or contracted for hire to other organizations.

Based on the above analysis it can be inferred that the optimal staffing mix is composed of 14.5 FTE covering all of the proposed language bundles. See table below.

CENTRALIZED MODEL	ESTIMATED CAPACITY			ESTIMATED DEMAND		EXCESS CAPACITY		
INTERNAL INTERPRETERS	FTE	VISIT	PHONE	VISIT	PHONE	DAYS FOR VISITS	DAYS FOR PHONE	TOTAL EXCESS DAYS
Mandarin/Cantonese	5	4875	2438	4554	2277	54	11	64
Spanish/ Portuguese/ Italian/ French	6.5	6337.5	3169	6119	3059	36	7	44
Vietnamese	1.5	1462.5	731	1002	501	77	15	92
Punjab Urdu/Hindu	1.5	1462.5	731	585	293	146	29	175
Other Languages	External	N/A	N/A	12260	6130	N/A	N/A	N/A

Based on the average salary rate and estimated productivity, 18,390 requests could be filled internally at an average cost of \$51.25 per request. 8,729 requests would still need to be filled using external resources, likely at a cost of less than \$66.88 per request. Comparing the total aggregate spend of the surveyed institutions of \$2,285,434 with the costs associated with the proposed model, \$942,500 (labour), \$583,790 (external services), \$300,000 (operating/equipment) it can be concluded that the proposed centralized service model if deployed could have saved the surveyed institutions approximately \$459,144.

In addition, existing excess capacity within the model could have been utilized to fulfill 321 phone and 256 visit requests for Mandarin/Cantonese; 218 phone and 175 visit requests for Spanish/ Portuguese/ Italian/ French; 460 phone and 368 visit requests for Vietnamese and 862 phone and 690 visit requests for Punjab/Urdu/Hindu, within other HSPs.

Overall, the proposed model better matches supply with demand for interpretation services by achieving economies of both scale and scope resulting in reduced costs and improved access for all of the HSPs in question.

### 1. University of Texas, M.D. Anderson Cancer Center, Houston, Texas

Mr. Cesar Palacio, Language Assistance, Manager

Marking nearly seven decades of Making Cancer History, The University of Texas M. D. Anderson Cancer Center is located in Houston on the campus of the Texas Medical Center. It is one of the world's most respected centers devoted exclusively to cancer patient care, research, education and prevention. The main campus is situated within the Texas Medical Center in Houston and includes two research campuses in Bastrop County, Texas. The Center also includes six satellite centers. In Fiscal Year 2009, more than 96,000 people — over one-third of them new patients — sought the high-quality care that has made M. D. Anderson so widely respected. Of those patients, more than 11,000 participated in clinical trials exploring novel treatments, the largest such program in the nation. The M.D. Anderson Cancer Center employs 17,000 people.

#### The Model

The Language Assistance Model for the Center includes 23 staff interpreters who speak 9 languages in combination with an external agency to assist in providing 35 different language needs for face to face. Twenty of the interpreters are housed in the main campus and three in a secondary building. The satellite centers are handled by phone.

Telephone interpreter service is also available 24 hours per day. The total number of face to face interactions is approximately 100,000 which are all organized in advanced by phone (90%) or e-mail (10%). About 18% of interactions are telephone based which total about 4000 hours by the internal staff interpreters and 6000 hours supplied by an external agency. This organization has been investigating video spoken and sign language interpreters but has not implemented as yet.

Hospital culture is to provide face-to-face interpretation, but due to increased volume there are increasing push to have staff use the phone interpreters. Criteria have been developed to assist staff to identify the most appropriate method of interpretation. The Centre has developed a data base for dispatching interpreters according to need. For example if the appointment is going to be more

than 22 minutes (ie. admission), it is more efficient to use a face-to-face interpreter.

The interpreter program is well established and has been in place for 17 years.

Issues: Two years ago switched OPI providers; 40% of staff was resistant with using the phone. Secretaries are very well-trained to direct staff to phone when face-to-face was not available.

Challenges with past provider included:

- Wait time #1 complaint (> 45 minutes)
- #2 complaint was interpreters' lack of medical terminology
- #3 lack of interpreter training, for example arguing or having a conversation with patients
- Language line was last provider.

Patients are more willing to use video than phone service.

### 2. Children's Medical Center Dallas, Dallas Texas

Mr. Edgardo Garcia, Director of Translation Services

Children's Medical Center is private, not-for-profit, and is one of the largest pediatric healthcare providers in the nation. As the only academic healthcare facility in North Texas dedicated exclusively to the comprehensive care of children from birth to age 18, Children's provides patient care ranging from simple eye exams to specialized treatment in areas such as heart disease, hematology-oncology and cystic fibrosis. As the primary pediatric teaching facility for The University of Texas Southwestern Medical Center at Dallas, the medical staff at Children's conducts research that is instrumental in developing treatments, therapies, and greater understanding of pediatric diseases.

The Children's system is licensed for 559 beds and has more than 50 subspecialty programs. The Dallas hospital was the first designated Level I trauma center for paediatrics in Texas. To better serve the region's growing pediatric population, the 72-bed Children's Medical Center at Legacy opened in 2008 in Plano, Texas. Children's has more than 360,000 visits each year.

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Children's established their Language Service department in 1994. The language service model for the two hospital sites includes F2F while the several satellite clinics use telephone interpretation. There are approximately 160,000 requests per year with approximately 275 calls per day. The Language Service meets about 92 to 93% of requests. Service is offered 24/7. The department includes approximately 50 interpreters: 25 full-time interpreters for Spanish-English translation and other languages as needed. The interpreters are deployed according to volumes. The Center uses four to five 3rd party vendors for F2F and uses two vendors for telephone services.

Technology used includes traditional telephone lines with speakerphones and more recently video interpretation using Language Access Network, a wireless, T1 connection supplied by the company MARDDI. The implementation of technology solutions was facilitated through the use of physician champions and support from senior management. The data collected in relation to the service is compiled in a monthly report that includes where services are provided, how much time for each service, and patient satisfaction.

The interpreter selection process includes:

- Pre-screening test for medical terms

Language validation test with 3rd party (looking for 90% score or above) Once hired, interpreters receive 40 to 60 hours of training

The operating budget for the service is approximately US\$1.2 million and is funded by gifts due to the not-for-profit status of the organization.

**3. University of New Mexico Hospital,  
Albuquerque, New Mexico**  
Mr. Marcel Tafoya, Director,  
Language Interpreter Services

The University of New Mexico Health Sciences Center is the largest academic health complex in the state. Located on the University of New Mexico campus in Albuquerque, the HSC combines its four mission areas, education, research, patient care and community outreach, to provide New Mexicans with the highest level of health care.

The UNMHSC was created in 1994 when the UNM Board of Regents united the health-related academic and clinical components of the university: UNM Hospitals, UNM College of Nursing, UNM School of Medicine, UNM Cancer Research & Treatment Center, UNM College of Pharmacy, and UNM Health Sciences Library and Informatics Center.

The Interpreter Language Services Program at UNM Hospitals provides professional medical Interpreters to limited-English-proficient and hearing-impaired patients and was established in 2005. On-site Interpreters facilitate communication between providers and patients, family and visitors. Interpreters are available for clinic visits to interpret and translate for all medical encounters.

Interpreters and translators have met all the qualifications for both written and oral American Council of the Teaching of Foreign Languages test. All Interpreters have successfully completed a professional training program for medical interpreters.

The organizational mission is to provide quality service by decreasing barriers to health care for limited-English-proficient and hearing-impaired patients who receive their care at UNM hospitals.

The service delivery model includes F2F in the following languages: Spanish, Vietnamese, and Navajo. There is also a video call center on campus with 55 mobile video monitors deployed. There is a dedicated T1 line connection for video for which they have no problem providing ASL 24/7. The call center has 3 Spanish and 1 Vietnamese interpreter available Monday to Friday. Volumes include outpatient visits which total 5000 requests per month. On average, 1300 per month are met F2F through interpreters or dual role interpreters or bilingual providers, video meets 250 per month and Pacific Telephone interpreters meet 500 calls per month.

The Center also uses bilingual interpreters who are staff in the organization. These staff are trained and tested and are paid a stipend for their services. The training of bilingual staff includes a 40 hour medical interpretation program called Bridging the Gap and eight hours

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of shadowing a year. The third party vendors used for telephonic interpretation are Pacific Interpreters while the Video Conference system is automated through Paras and Associates, another vendor. People tend to feel more comfortable with the video interpretation than telephone. Video equipment was allocated through grants, etc. (~US\$500,000). Video units are wireless and only need a power source. The organization is looking into battery operated carts.

- Boot up time of equipment is an issue (~2 minutes)
- Looking to have a few monitors as a fleet.
- CISCO video phones in call center and CISCO video mobile monitors

Documentation is at times a challenge, matching appointments that are made with end of visit and what form of service was used. Also telephone interpretation is at times a challenge due to provider preference for F2F or video.

In order to monitor quality, the department educator randomly chooses interpreters to go through a scorecard exercise. Interpreters are shadowed and scored, and then an action plan is created for a period of time during which improvement has to be made. This is tied to annual review process. The score also considers patient and provider input. Patient satisfaction surveys in three languages are sent out with three questions on the survey related to interpretation.

Indicator being measured in hours of use of each modality include:

- Telephone
- Dual role
- Staff
- Tracking patient satisfaction
- Time to connect

In order to continue to assess patient language needs the hospital meets on a quarterly basis with the community to create a five-year work plan with action items.

The operating budget of the program is just over \$1,000,000. The budget pays staff salaries for 14 Spanish

interpreters, 3 Vietnamese interpreters, 1 clerk, 1 office supervisor, 1 department educator, and 1 director. There is also a budget for interpreter/translators to translate documents; \$300,000 is allocated for this purpose, mostly for education materials.

#### **4. Winnipeg Regional Health Authority, Winnipeg, Manitoba**

Jeannine Roy, Manager, WRHA Language Access

The Winnipeg Regional Health Authority is an organization of committed professionals who support each other in the delivery of health services and work to protect the health and promote the well being of the people who benefit from these services.

The Winnipeg Health Region serves residents of the City of Winnipeg as well as the rural municipalities of East and West St. Paul, with a total population of just over 700,000 people. The Winnipeg Regional Health Authority (WRHA) also provides health care support to nearly half a million Manitobans who live beyond these boundaries as well as residents of Northwestern Ontario and Nunavut who require the services and expertise available within the Winnipeg Health Region.

More than 28,000 people work in the Winnipeg Health Region. With an annual operating budget of nearly \$1.8 billion dollars, the Winnipeg Regional Health Authority operates or funds over 200 health service facilities and programs including: Health Sciences Centre, St. Boniface General Hospital, Concordia Hospital, Grace Hospital, Seven Oaks General Hospital, Victoria General Hospital, Deer Lodge Centre, Misericordia Health Centre, Riverview Health Centre, St. Amant, 35 Personal Care Homes, 12 Community Health Agencies, 20 Community Health Offices, Rehabilitation Centre for Children, Manitoba Adolescent Treatment Centre, Funded community agencies, Pan Am Clinic, Community offices offering programs involving public health, Home Care, Health services including: Long Term Care, Primary Care, Home Care, Mental Health, and Acute Care, and Two ACCESS Centres; River East and Transcona.



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The WRHA Language Access program provides language services to individuals receiving health-care services, as well as to health-care providers who need to communicate with patients or clients with limited English proficiency. Language Access employs 60 trained interpreters who deliver in-person interpreting services in 32 languages. Over-the-phone interpreter services are also available in over 175 languages.

The following are components of the WRHA language service:

- Established a single point of access by phone
- In-house training (72 hour program)
- Interpreters available 24/7
- Regional policy
- Now providing services outside of health on a cost recovery basis
- All employees are WRHA employees – all casual and on call
- Interpreters provided mostly in person
- Provide services to any doctor's offices in Winnipeg

The challenges involved with implementation included the large number of employees in the WRHA, totalling 28,000 on nearly 200 sites. In order to market the new system it was necessary to have dedicated resources to communicate and educate about the service. Marketing focused on reducing risk as a change strategy.

Initial evaluation of the system identified the following needs:

- adequate permanent funding
- enhanced dispatch functionality,
- provincial model (based on success of program) that will extend beyond health,
- long-term strategy for continual training,
- further education of service providers and communication about service availability
- Clients cannot self refer currently but should be able to
- Challenges of invoicing – need a payroll clerk.

There have been some challenges to the uptake of the telephone technology. A small group are reluctant to use telephones for this service, but on the whole most like it. The organizations have not implemented dual handset telephones; they use speaker phones which require private rooms to ensure confidentiality. Telephone service is easily accessed through a unique one-time use authorization code to control its usage. Video interpretation is available through telehealth links.

Successes in advancing the program have included permanent funding (~\$500,000) as well as funding by the Ministry of Labour and Immigration for training, term positions for recruitment and training, and communication strategy. The WRHA ensures formal testing of language service providers as a standard of practice and they have advocated for formalized language fields built into electronic patient record to make data collection easier.

### Improving Health Equity through Language Access: Medical Interpretation and Remote Technology Survey

#### PURPOSE OF SURVEY:

Thank you for taking the time to fill out this important survey about language services in your organization.

**The survey will take approximately 30–45 minutes to complete.** The sections are divided into demographics; general information; policies, standards and guidelines; resources; and technology. This information will be used to inform a Toronto Central LHIN initiative focused on developing a LHIN wide model for interpretation services. It may be necessary to delegate specific sections of the survey to the most appropriate respondent in your organization in order to answer the questions as accurately as possible. **Please return the completed survey by January 29, 2010.** We look forward to sharing the results of the survey and the overall project outcomes

#### DEMOGRAPHIC:

**1. Indicate which category/type best describes your organization.**

- |                                                         |                                                              |
|---------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Teaching hospital              | <input type="checkbox"/> Community Care Access Centre (CCAC) |
| <input type="checkbox"/> Community hospital             | <input type="checkbox"/> Long Term Care Facility             |
| <input type="checkbox"/> Community Social Service (CSS) | <input type="checkbox"/> Rehabilitation                      |
| <input type="checkbox"/> Community Health Centre (CHC)  | <input type="checkbox"/> Other. Please Specify _____         |

**2. How many staff are employed at your organization?**

- |                               |                                 |                                  |                                           |
|-------------------------------|---------------------------------|----------------------------------|-------------------------------------------|
| <input type="checkbox"/> 1-50 | <input type="checkbox"/> 51-150 | <input type="checkbox"/> 151-500 | <input type="checkbox"/> Greater than 500 |
|-------------------------------|---------------------------------|----------------------------------|-------------------------------------------|

**3. What type of service(s) does your organization deliver? (more than one may be indicated)**

- |                                             |                                         |                                          |                                                      |
|---------------------------------------------|-----------------------------------------|------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Health promotion   | <input type="checkbox"/> Primary care   | <input type="checkbox"/> Tertiary care   | <input type="checkbox"/> Other. Please Specify _____ |
| <input type="checkbox"/> Illness prevention | <input type="checkbox"/> Secondary care | <input type="checkbox"/> Quaternary care |                                                      |

**4. How many patients/clients are seen by your organization/agency monthly in total (include inpatient and outpatient if applicable)?**

- |                                        |                                     |                                      |
|----------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Less than 100 | <input type="checkbox"/> 100 to 500 | <input type="checkbox"/> 501 to 1000 |
|----------------------------------------|-------------------------------------|--------------------------------------|

#### GENERAL INTERPRETATION SERVICES INFORMATION:

**5. What percentage of patients/clients do you encounter with Limited English Proficiency (LEP)?**

- |                                  |                                   |                                           |
|----------------------------------|-----------------------------------|-------------------------------------------|
| <input type="checkbox"/> none    | <input type="checkbox"/> 26 – 50% | <input type="checkbox"/> 76 – 100%        |
| <input type="checkbox"/> 1 – 25% | <input type="checkbox"/> 51 – 75% | <input type="checkbox"/> Unable to answer |

**6. How often does your organization use interpretation to deliver services to patients/clients?**

- |                                              |                                               |                                                |
|----------------------------------------------|-----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Never               | <input type="checkbox"/> 26 – 50% of the time | <input type="checkbox"/> 76 – 100% of the time |
| <input type="checkbox"/> 1 – 25% of the time | <input type="checkbox"/> 51 – 75% of the time | <input type="checkbox"/> Unable to answer      |

**7. On average, how far in advance do you receive a request for an interpreter?**

- |                                                |                                                   |                                                             |
|------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Urgent (0 to 4 hours) | <input type="checkbox"/> Same day (5 to 23 hours) | <input type="checkbox"/> Pre-booked (greater than 24 hours) |
|------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------|

**8. On average, how many interpretation requests do you receive on a monthly basis? \_\_\_\_\_**

- ☐ Do not collect this data

**9. On average, what percentage of interpretation requests are met on a monthly basis?**

- ☐ 1 – 25%      ☐ 51 – 75%      ☐ Do not collect this data  
☐ 26 – 50%      ☐ 76 – 100%

**10. Approximately what percentage of interpretation requests do you fill through:**

	NOT USED	1 – 25%	26 – 50%	51 – 75%	76 – 100%	DO NOT COLLECT
In-house staff interpreters?						
Casual						
Full-time						
Part-time						
Internal Bilingual Volunteers?						
Bilingual Clinical staff?						
Bilingual Non-Clinical staff?						
Independent Freelance Interpreters?						
Contracted or Agency?						
Telephone interpretation service?						
Community language bank?						
Family/friends of the patients/clients?						
Interpretation services are not available/not applicable						

**11. How is interpretation services funded in your organization? Select all that apply.**

- ☐ Global budget      ☐ Corporate sponsor  
☐ Ministry of Health and Long Term Care      ☐ Specific Department  
☐ Fundraising/ Foundation      ☐ Not funded  
☐ External funding agency      ☐ Other, please specify: \_\_\_\_\_

**12. What is your total annual budget for interpretation services? \_\_\_\_\_**

- ☐ Not applicable

**13. Does your organization translate patient/client materials?** ☐ Yes ☐ No

If yes, please indicate ☐ In-house translators ☐ Using translation agencies

**14. Do you have an annual budget for document translation?** ☐ Yes ☐ No

If yes, what is your annual budget? \_\_\_\_\_

**15. What are your top 5 languages requested?**

- |                                                 |                                     |                                                      |
|-------------------------------------------------|-------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Italian    | <input type="checkbox"/> Spanish                     |
| <input type="checkbox"/> Arabic                 | <input type="checkbox"/> Korean     | <input type="checkbox"/> Tagalog                     |
| <input type="checkbox"/> Cantonese              | <input type="checkbox"/> Mandarin   | <input type="checkbox"/> Tamil                       |
| <input type="checkbox"/> Farsi                  | <input type="checkbox"/> Polish     | <input type="checkbox"/> Vietnamese                  |
| <input type="checkbox"/> French                 | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Other, Please Specify _____ |
| <input type="checkbox"/> Greek                  | <input type="checkbox"/> Punjabi    |                                                      |
| <input type="checkbox"/> Gujarati               | <input type="checkbox"/> Russian    |                                                      |

**16. Identify the barriers that you face in providing interpretation services. Check all that apply.**

- |                                                                      |                                                                                                    |
|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Identification of patient/client needs      | <input type="checkbox"/> Staff uncomfortable asking for language information from patients/clients |
| <input type="checkbox"/> Cost/reimbursement concerns                 | <input type="checkbox"/> Staff do not have enough time to coordinate services                      |
| <input type="checkbox"/> Lack of technology (computers, phones, etc) | <input type="checkbox"/> Other barriers/gaps. Please specify: _____                                |
| <input type="checkbox"/> Lack of training resources                  |                                                                                                    |
| <input type="checkbox"/> Lack of community-level data                |                                                                                                    |

**17. How does your organization assess the language needs of the community you serve? Check all that apply.**

- |                                                              |                                                      |
|--------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Census data                         | <input type="checkbox"/> Other, please specify _____ |
| <input type="checkbox"/> Tracking of actual patients/clients | <input type="checkbox"/> Do not assess               |
| <input type="checkbox"/> Interpretation services usage       |                                                      |

**18. If you collect language information, from the following list, please indicate the type of language information you collect from patients/clients and how the data are collected.**

- ☐ No language information is collected

	IN PATIENT/ CLIENT CHART	THROUGH ONTARIO MENTAL HEALTH REPORTING SYSTEM	RAI (RESIDENT ASSESSMENT INSTRUMENT)	OTHER, PLEASE SPECIFY
Language spoken at home				
Preferred language				
Country of origin				
Ethnicity				
Mother tongue				
Primary language				
Need for interpreter of a given language				
Other				
Contracted or Agency?				
Telephoniinterpretation service?				

**19. Do you have policies, procedures and/or standards related to interpretation services in your organization?**

	HAVE	IN DEVELOPMENT	PLAN TO HAVE WITHIN NEXT YEAR	DO NOT HAVE	COMMENTS
Staffing related Guidelines					
Process related Guidelines					
Standards					
Policies					
Procedures					
Other					

**POLICIES AND PROCEDURES**

An initial community assessment revealed a lack of consistent policies, standards and guidelines in relation to language services at both a macro and micro level. The following questions are aimed to assist in the development of recommendations for standardization to ensure equitable care experiences across settings.

**20. What program/department does your Interpretation services fall under?**

- |                                                      |                                                          |
|------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Quality and Risk Management | <input type="checkbox"/> Patient/client Support Services |
| <input type="checkbox"/> Human Resources             | <input type="checkbox"/> Diversity                       |
| <input type="checkbox"/> Patient/client Care Program | <input type="checkbox"/> Other, please specify _____     |

**21. Which areas of your organization are interpreters requested most? Check all that apply.**

- |                                               |                                                                           |
|-----------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Emergency Department | <input type="checkbox"/> Specialty clinic, please identify (top 3): _____ |
| <input type="checkbox"/> ICU                  | _____                                                                     |
| <input type="checkbox"/> Inpatient            | <input type="checkbox"/> Other, please specify _____                      |
| <input type="checkbox"/> Outpatient           | _____                                                                     |

**22. What are the top 3 situations in which interpreters are used in your organization?**

- |                                                  |                                                      |
|--------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Unable to answer        | <input type="checkbox"/> Counseling                  |
| <input type="checkbox"/> Consent                 | <input type="checkbox"/> Palliative care decisions   |
| <input type="checkbox"/> Patient/client teaching | <input type="checkbox"/> Assessments                 |
| <input type="checkbox"/> Admission               | <input type="checkbox"/> Emergency                   |
| <input type="checkbox"/> Discharge               | <input type="checkbox"/> Inpatients                  |
| <input type="checkbox"/> Follow up               | <input type="checkbox"/> Mental Health               |
| <input type="checkbox"/> Treatment options       | <input type="checkbox"/> Other, please specify _____ |

### HUMAN RESOURCES FOR INTERPRETATION SERVICES:

Organizations have varying resources available for interpretation and translation. The following questions will help identify the current state of resources in various organizations to better understand gaps and provide a basis to develop strategies and solutions for human and written resources.

**23. Please describe the structure of your interpretation service, i.e. interpretation service availability and alternative. Check all that apply.**

- |                                                                                                                           |                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Number of In-house staff interpreters                                                            | <input type="checkbox"/> Independent Freelance Interpreters                                 |
| i. Casual _____                                                                                                           | <input type="checkbox"/> Contracted or Agency                                               |
| ii. Full-time _____                                                                                                       | Identify agencies _____                                                                     |
| iii. Part-time _____                                                                                                      | <input type="checkbox"/> Telephoniiinterpretation service                                   |
| <input type="checkbox"/> Internal Bilingual (English plus at least one other language) Volunteers used for interpretation | <input type="checkbox"/> Community language bank                                            |
| <input type="checkbox"/> Bilingual (English plus at least one other language) Clinical staff used for interpretation      | <input type="checkbox"/> Family/friends of the patients/clients                             |
| <input type="checkbox"/> Bilingual (English plus at least one other language) Non-Clinical staff used for interpretation  | <input type="checkbox"/> Interpretation services are not available/<br>not applicable _____ |

**24. Is your face-to-face interpretation service:**

- |                                                                           |                                                      |
|---------------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Centralized (Coordinated by specifidepartment)   | <input type="checkbox"/> Other, please specify _____ |
| <input type="checkbox"/> Decentralized (coordinated at the program level) |                                                      |

**25. If you have staff interpreters, are they required to have any of the following training/qualifications/certifications?**

- |                                                                                                                              |                                                                     |
|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Language Interpreter Training Program<br>(at Ontario Colleges)                                      | <input type="checkbox"/> License from Ministry of Attorney General  |
| <input type="checkbox"/> Community-Based Interpreter Training<br>(e.g., MCIS, Barbara Schleiffer Clinic,<br>Access Alliance) | <input type="checkbox"/> License from Immigration and Refugee Board |
| <input type="checkbox"/> ILSAT                                                                                               | <input type="checkbox"/> Other, please specify _____                |
| <input type="checkbox"/> CILISAT                                                                                             |                                                                     |

**26. If you use bilingual volunteers and bilingual staff for interpretation, please indicate the average number of hours of training received.**

	VOLUNTEERS	CLINICAL STAFF	NON-CLINICAL STAFF
No training			
1 to 20 hours			
21 to 40 hours			
41 to 80 hours			
81+ hours			

## TECHNOLOGY RELATED INFORMATION

Best practices in healthcare interpretation feature a hybrid model of interpretation service provision, including face-to-face, telephone interpretation and video-conference interpretation solutions. The following are baseline questions to understand the potential for utilizing technology in accessing language services to better meet patient/client needs.

If you do not have the available Information Technology (IT) resources/expertise to answer any of these questions, please indicate here:

☐ **Do not** have the available resources to answer any of the questions.

**27. Do you have a Local Area Network (LAN) in areas where you use or would like to use interpretation services? (i.e, computers that are networked, either wired or wireless)**

- |                                                   |                                                  |                                           |
|---------------------------------------------------|--------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Yes                      | <input type="checkbox"/> No                      | <input type="checkbox"/> Partially        |
| <input type="checkbox"/> Currently in development | <input type="checkbox"/> Planned within one year | <input type="checkbox"/> Unable to answer |

**28. Are you able to expand your current IT infrastructure to add additional wired or wireless LAN devices?**

- |                                                   |                                                  |                                           |
|---------------------------------------------------|--------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Yes                      | <input type="checkbox"/> No                      | <input type="checkbox"/> Partially        |
| <input type="checkbox"/> Currently in development | <input type="checkbox"/> Planned within one year | <input type="checkbox"/> Unable to answer |

If yes, for these additional devices, are you able to route the traffic to eHealth Ontario's ONE network or the Internet?

- |                              |                             |                                           |
|------------------------------|-----------------------------|-------------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unable to answer |
|------------------------------|-----------------------------|-------------------------------------------|

**29. Do you have Voice and/or Video Over Internet Protocol (VOIP) implemented on your network?**

- Voice:
- |                                                   |                                                  |                                           |
|---------------------------------------------------|--------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Yes                      | <input type="checkbox"/> No                      | <input type="checkbox"/> Partially        |
| <input type="checkbox"/> Currently in development | <input type="checkbox"/> Planned within one year | <input type="checkbox"/> Unable to answer |

- Video:
- |                                                   |                                                  |                                           |
|---------------------------------------------------|--------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Yes                      | <input type="checkbox"/> No                      | <input type="checkbox"/> Partially        |
| <input type="checkbox"/> Currently in development | <input type="checkbox"/> Planned within one year | <input type="checkbox"/> Unable to answer |

**30. Are you able to prioritize Voice and/or Video Over Internet Protocol (VOIP) traffic?**

If yes, please describe what methods are used or are available for use?

- Voice:
- |                                                   |                                                  |                                           |
|---------------------------------------------------|--------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Yes                      | <input type="checkbox"/> No                      | <input type="checkbox"/> Partially        |
| <input type="checkbox"/> Currently in development | <input type="checkbox"/> Planned within one year | <input type="checkbox"/> Unable to answer |

**Prioritization Methods:**

- |                                                            |                                                             |                                       |
|------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Based on VLAN                     | <input type="checkbox"/> Based on MAC address of the device | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Based on IP Address of the device | <input type="checkbox"/> Based on protocol                  | _____                                 |

- Video:
- |                                                   |                                                  |                                           |
|---------------------------------------------------|--------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Yes                      | <input type="checkbox"/> No                      | <input type="checkbox"/> Partially        |
| <input type="checkbox"/> Currently in development | <input type="checkbox"/> Planned within one year | <input type="checkbox"/> Unable to answer |

**Prioritization Methods:**

- |                                                            |                                                             |                                       |
|------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Based on VLAN                     | <input type="checkbox"/> Based on MAC address of the device | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Based on IP Address of the device | <input type="checkbox"/> Based on protocol                  | _____                                 |



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**31. Would you be able to provide a dedicated routable Virtual Local Area Network (VLAN) for devices that may be used for accessing interpretation services?**

- ☐ Yes ☐ No ☐ Partially  
☐ Currently in development ☐ Planned within one year ☐ Unable to answer

**32. Can you dynamically assign network devices to a Virtual Local Area Network (VLAN). If yes, please describe what methods are used or are available to be used?**

- ☐ Yes ☐ No ☐ Partially  
☐ Currently in development ☐ Planned within one year ☐ Unable to answer

**VLAN Assignment Methods:**

- ☐ Based on IP address of the device ☐ Based on the protocol  
☐ Based on MAC address of the device ☐ Other: \_\_\_\_\_  
☐ Based on the hostname assigned to the device

**33. Can you provide Power Over Ethernet (POE) connection for wired devices if required for interpretation services?**

- ☐ Yes ☐ No ☐ Partially  
☐ Currently in development ☐ Planned within one year ☐ Unable to answer

**34. Do you have Information Technology resources to assist with implementation and IT related initiatives?**

Budget ☐ Yes ☐ No      Expertise (Internal) ☐ Yes ☐ No      Expertise (Outsourced) ☐ Yes ☐ No

**35. As we develop a model for interpretation services across the Toronto Central LHIN, would you be willing to share your policies, procedures and/or standards documents to assist us in this development process?**

☐ Yes

Please indicate the name of your organization and if possible, the name of a person we can contact.

\_\_\_\_\_

- ☐ No ☐ Maybe ☐ Not applicable

### CULTURAL COMPETENCY EDUCATION FOR HEALTH CARE PROVIDERS

#### Example

#### *Outline of Cultural Competence for Healthcare Professionals*

##### *Workshop Day 1*

*8:30am – 4:00pm*

Day 1 of the Cultural Competence Workshop for Healthcare Professionals introduces the concept of cultural competence and provides participants an opportunity to reflect on personal biases, assumptions and prejudices that can impact the quality of interactions with patients/families and influence care. This is an interactive session using discussion, small-group activities, film, case studies and self-reflective activities to learn about clinical cultural competence.

#### **Learning outcomes**

At the end of today's session participants will understand:

The types/impacts of settlement stressors experienced by new immigrant parents and children;

The impact of personal and professional beliefs, assumptions and biases on healthcare interactions with new immigrants;

The links between clinical cultural competence and patient safety, family/patient-centred care;

How to use knowledge of cultural differences to assess and respond to the needs of new immigrant parents and children;

How to access resources that enhance clinical cultural competence.

#### **Outline of Day 1**

##### **Morning**

Social determinants of health

- Reasons for immigration
- Differences between refugees and immigrants/culture shock and PTSD
- Stressors affecting Immigrants during resettlement process

- Research related to health disparities, health benefits of equity
- What is Culture? Visible and non-visible aspects of culture

##### **Afternoon**

- Culture care framework, self-assessment
- Understanding cultural competence, actions supporting cultural competence
- Links between cultural competence and family-centred care, patient safety
- Practicing cultural competence
- Cultural assessment tools
- Overcoming language barriers, working effectively with Interpreter Services and Language Line
- Reflective exercises to prepare for Day 2

#### *Outline of Cultural Competence for Healthcare Professionals*

##### *Workshop Day 2*

*8:30am – 4:30pm*

Day 2 of the Cultural Competence Workshop for Healthcare Professionals will provide participants an opportunity to apply learning from Day 1 to clinical scenarios that reflect complex clinical/cultural situations that healthcare professionals face in their practice. The session will focus on clinical concepts including: Parenting, Mental Health, Complementary and Alternative Medicine, Pain, and Palliative Care-Bereavement. This is an interactive session which will utilize reflective discussion, small-group activities, film, case studies and standardized patients to apply knowledge about clinical cultural competence. Content for the workshop was developed in collaboration with various expert clinical teams and others at SickKids.

#### **Learning Outcomes**

At the end of this session, participants will:

- Deepen their awareness of personal biases and their impact on the patient/family-healthcare provider relationship
- Understand how to use cultural assessment tools in clinical practice
- Understand and apply strategies to engage in collaborative conversations

- Apply cultural competence knowledge in clinical situations relating Parenting, Pain Assessment and Management, Mental Health, Complementary and Alternative Therapies, and Bereavement/Grief

## **Outline of Day 2**

### **Morning**

- Reflections on Day 1 (including review of take-away activities)
- Culture and Communication, Culture and Decision-making, Cultural Assessment, Collaborative Conversations Strategies (CPS model, Greene, 2009)
- Parenting
- Mental Health
- Pain

### **Afternoon**

- Complementary and Alternative Medicine
- Bereavement & Grief
- Application to Practice with Standardized Patients
- Commitment to Change, Evaluation & Next Steps

## **Clinical Module-Specific Learning Objectives**

### **1. Collaborative Conversations & Cultural Assessment**

- To understand the impact of culture on communication;
- To understand how to apply strategies to engage in a collaborative conversation to enhance communication with children/family;
- To understand how to use Cultural assessment to assess the needs of children/family.

### **2. Parenting**

- To understand ways in which a family's cultural identity plays a role in goals parents set for children and how they parent;

- To demonstrate how understanding a family's cultural identity affects care we provide to achieve optimal health and development.

### **3. Mental Health**

- To understand the impact of culture and immigration on mental health needs of new immigrants;
- To learn how clinical cultural competence can enhance care and support mental health needs of new immigrants.

### **4. Pain**

- To identify the relationship between an individual's culture and attitudes towards health care;
- To recognize the influence of cultural values on perception of and responses to pain.

### **5. Complementary and Alternative Medicine**

- To understand how to assess parents' use of CAM for their child;
- To reflect on how a biomedical view of health care may differ from the health beliefs and practices of new immigrant families.

### **6. Bereavement and Grief**

- To understand how to identify and respond to culture and faith-specific practices related to death and dying, grief and bereavement;
- To understand the role of clinical cultural competence in end of life care.

### RECOMMENDATION AND TOOLS FOR PROVIDERS

#### Tools:

- Cultural Assessment Guide ([www.sickKids.ca](http://www.sickKids.ca))
- Interpreter tip sheet/card
- Staff badges in different languages (to identify bilingual employees for assistance)
- Welcome cards, printed in many different languages, instructing patients to bring the card to the information desk if they need assistance; on the reverse side are instructions in English for how to contact interpreter services
- Language Identification charts can help LEP patients with requesting interpreter services. One such chart is organized into a 'patient-visitor' column which lists the questions "Do you speak\_\_\_\_?" in various languages, with a matching column indicating the name of the language in English. Statistical demographic data can be used to determine which languages to include.
- Wallet-sized cards with the patient's primary language written in English, as well as instructions on how to reach an interpreter for that language. Patients are able to provide this card at subsequent visits to specify their need for language assistance.

#### Recommendations:

- Intake assessment should include the following questioning: "Do you speak a language other than English at home?" Answer 'yes' or 'no'. If yes, "How well do you understand English?" Answer 'very well', 'well', 'a little', 'not at all'. If any answer other than 'very well' then the person would most likely benefit from interpreter services in their own language.
- Conduct daily inpatient interpreter rounds of LEP patients to assess additional patient needs and to reminding clinical staff to call interpreter services as needed.

#### Documentation:

When a patient self-identifies as not being fluent in English, the name of the hospital interpreter and the language used to interpret is documented in the patient's medical chart

If a patient declines a hospital interpreter, the reason for declining the service is requested and recorded in the patient's chart. The name of the person who interprets for the patient and her/his relationship to the patient (e.g. wife, friend, etc) should be recorded.

### **CULTURAL INTERPRETER LANGUAGE INTERPRETATION SKILLS ASSESSMENT TEST - CILISAT**

#### **INTERPRETER LANGUAGE INTERPRETATION SKILLS ASSESSMENT TEST - ILSAT**

These tools are designed to test an individual's language fluency in English and a second language, as well as his or her ability to perform consecutive interpreting and sight translation.

Sight translation is an oral translation of a written text. Two texts are presented, one in English and one in a second language. For each text, the candidate has up to 10 minutes to prepare. After the preparation time, the test administrator starts recording as the candidate interprets from English into the second language. Following the sight translation tests, candidates are given a five-minute break. After the break, the Consecutive Interpreting Test begins.

Consecutive interpreting is interpreting a conversation between two parties who do not speak the same language.

The candidate is required to switch between the two languages and interpret for both parties in turn.

The consecutive interpreting test requires that the candidate interpret with speed in the time allotted on the tape. The candidate is required to interpret into the second language as soon as the speaker finishes each segment and pauses. Following the pre-recorded segment, there is a segment of blank tape to allow the candidate to interpret.

The CILISAT/ILSAT is assessed by trained markers who are obligated to maintain impartiality and confidentiality. The test marking service providers are Across Languages Translation and Interpretation Service and Cultural Interpretation Service of Our Communities (CISOC).

The assessment is based on how well the candidate accurately conveys the meaning of the original text or dialogue and whether they omit, distort or add words or meaning that are not in the original text. For the CILISAT there is also a grade given to overall language proficiency.

## Appendix G: Testable Languages

### LANGUAGES FOR WHICH TESTING IS AVAILABLE IN ONTARIO

The CILISAT/ILSAT certification is currently available in 58 languages:

1. Albanian	16. French	31. Kurdish Sorani	44. Sinhala
2. Amharic	17. German	32. Low German	45. Slovak
3. Arabic	18. Greek	33. Mandarin	46. Slovenian
4. Armenian	19. Gujarati	34. Nuer	47. Somali
5. Assyrian	20. Hebrew	35. Oromo	48. Spanish
6. Bengali	21. Hindi	36. Pashto	49. Swahili
7. Bulgarian	22. Hungarian	37. Polish	50. Tagalog
8. Burmese	23. Indonesian	38. Portuguese	51. Tamil
9. Cantonese	24. Italian	39. Punjabi	52. Thai
10. Czech	25. Japanese	(Gurmukhi Script)	53. Tigrigna
11. Dari	26. Karen	40. Punjabi	54. Turkish
12. Dinka	27. Khmer (Cambodian)	(Perso-Arabic Script)	55. Twi
13. Dutch	28. Kinyarwanda	41. Romanian	56. Ukranian
14. Farsi (Persian)	29. Korean	42. Russian	57. Urdu
15. Finnish	30. Kurdish Kurmandji	43. Serbo-Croatian	58. Vietnamese

### CORE COMPETENCIES FOR INTERPRETERS

**Confidentiality:** Interpreters will treat all information learned during the interpreting as confidential.

**Impartiality:** Interpreters are aware of the need to identify any potential or actual conflicts of interest, as well as any personal judgments, values, beliefs, or opinion that may lead to preferential behavior or bias affecting the quality and accuracy of the interpreting performance.

**Respect for Individuals and their Communities:** Interpreters strive to support mutually respectful relationships between all three parties in the interaction (patient, provider and interpreter), while supporting the health and well-being of the patient as the highest priority of all healthcare professionals.

**Professionalism and Integrity:** Interpreters conduct themselves in a manner consistent with the professional standards and ethical principles of the healthcare interpreting professional.

**Accuracy and Completeness:** Interpreters transmit the content, spirit and cultural context of the original message into the target language, making it possible for patient and provider to communicate effectively.

**Cultural responsiveness:** Interpreters seek to understand how diversity and cultural similarities and differences have a fundamental impact on the healthcare encounter. Interpreters play a critical role in identifying cultural issues and considering how and when to move to a cultural clarifier role. Developing cultural sensitivity and cultural responsiveness is a life-long process that begins with an introspective look at oneself. (California Standards for Healthcare Interpreters, 2002; HIN, 2007★)



**Bilingual Person**

An individual who has some degree of proficiency in two languages. A high level of bilingualism is the minimum qualification for a competent interpreter but by itself does not ensure the ability to interpret.

**Certified Interpreter:**

A professional interpreter who is certified as competent by a professional organization through rigorous testing based on appropriate and consistent criteria. Interpreters who have had limited training or have taken a screening test administered by an employing legal, health, interpreter or referral agency are NOT considered certified.

**Health Care Interpreter**

A person who is readily able to communicate with an individual who has limited English proficiency, who can accurately translate the written or oral statements of the person with Limited English Proficiency into English, and who is readily able to translate the written or oral statements of other persons into the language of the person with Limited English Proficiency.

**Person with Limited English Proficiency**

A person who, by reason of place of birth or culture, speaks a language other than English and does not speak English with adequate ability to communicate effectively with a health care provider.

**Professional Interpreter**

A fluently bilingual individual with appropriate training and experience who is able to interpret with consistency and accuracy and who adheres to the Standards of Practice and Ethical Principles.

**Remote Interpreting**

Interpreting provided by an interpreter who is not in the presence of the speakers, e.g. interpreting via telephone or videoconferencing

**Video Conference Interpreting**

Remote interpreting that makes use of video camera when one or more of the interpreting parties are not present at the same location. The parties see and hear each other via a monitor.

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